

**PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION**

ON-THE-RECORD
98-D28

PROVIDER -A.O. Fox Memorial
Hospital
Oneonta, New York

DATE OF HEARING-
January 29, 1998

Provider No. 33-0085

Cost Reporting Period Ended -
December 31, 1986

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Blue Cross and Blue Shield

CASE NO. 87-0480E

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ISSUE:

Was the Intermediary's denial of the Provider's request for rural referral center status for the fiscal year ended December 31, 1986 proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

A.O. Fox Memorial Hospital ("Provider") is a short term, acute care hospital located in Oneonta, New York. Until January 1, 1986, hospitals in New York State were not reimbursed under the Medicare program's prospective payment system ("PPS") because they were subject to statewide demonstration projects. Accordingly, the Provider's fiscal year ended December 31, 1986, was its first year under PPS for Medicare reimbursement purposes. Pursuant to 42 U.S.C.

§ 1395ww(d)(5)(C)(i) and the implementing regulations at 42 C.F.R. § 412.96, the Provider requested that it be designated a rural referral center ("RRC") for purposes of PPS reimbursement which became effective on January 1, 1986. The Provider's application for RRC status for fiscal year 1986 was submitted to the Regional Administrator of the Health Care Financing Administration ("HCFA") on April 28, 1986.¹ The Provider's RRC request was subsequently directed to Empire Blue Cross and Blue Shield ("Intermediary") on May 12, 1986,² and was later supplemented by the Provider in a letter to the Intermediary dated June 17, 1986.³ On August 1, 1986, the Intermediary denied the Provider's RRC classification request due to untimely filing.⁴ The Intermediary cited the Federal Register dated August 31, 1984 (49 Fed. Reg. 34,742) which states that appeals relating to RRC status must be submitted during the quarter before the first quarter of the hospital's cost reporting period.⁵

The Provider appealed the Intermediary's denial of RRC status to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The estimated amount of Medicare reimbursement in controversy is approximately \$285,000. The Provider was represented by David B. Palmer, Esquire, of Akin, Gump, Strauss, Hauer and Feld. The Intermediary's representative was William E. Cymer, Senior Consultant, of the Blue Cross and Blue Shield Association.

¹ Intermediary Exhibit I-6.

² Intermediary Exhibit I-7.

³ Intermediary Exhibit I-8.

⁴ Intermediary Exhibit I-9.

⁵ Intermediary Exhibit I-4.

In the interest of facilitating the presentation of this issue before the Board as a hearing on the written record, the parties submitted the following joint stipulations:

1. The issue to be decided in this appeal is stated in the Board's June 16, 1997 NOTICE OF HEARING as follows:

Was the Intermediary's denial of the Provider's request for rural referral center status for FYE December 31, 1986 proper?

The parties agree that the above issue raises purely legal questions relating to the applicability of the deadline for filing for RRC status for FYE December 31, 1986.

2. To resolve the captioned appeal, the parties agree that a live hearing before the Board is unnecessary because the issues are purely legal ones that do not require factual testimony, and that the record of this case already includes all of the information necessary for the Board's decision, including the parties' position papers and supporting exhibits, and this stipulation.

3. The parties agree that the Provider met the substantive qualifications to be classified as an RRC for FY 1986, having the requisite case mix index, number of discharges, and percentage of specialists on its medical staff. Specifically, the Provider had over 6,000 adult and pediatric discharges, not including PPS-excluded units, in 1984, as set forth in the audited cost report issued by Blue Cross for that period, a case mix index of 1.1722 for FY 1985, as set forth at 51 Fed. Reg. 51545 (September 3, 1986), and the requisite minimum percentages of board-certified or eligible specialists on its medical staff for 1986, as set forth in the letter and list contained in Exhibit I-6 accompanying the Intermediary's position paper.

4. The Provider did not apply in 1985 for RRC status for 1986, because it believed that it did not qualify. However, in April 1986, it did thereafter apply for RRC status for 1986, based upon a theory that it subsequently abandoned. This 1986 application was denied as untimely.

5. The parties hereby expressly reserve their appeal rights as to the Board's decision, including the right to submit arguments in connection with Administrator's review of the Board's decision. The Hospital also reserves its right to judicial review of the final agency decision on this issue, including, without limitation, its right to submit arguments in court.

PROVIDER'S CONTENTIONS:

The Provider contends that its 1986 RRC application was untimely solely because of HCFA's patently misleading and erroneous statements about the base period governing eligibility. In

1985, HCFA published regulations at 42 C.F.R. § 412.96 setting forth the criteria under which hospitals could qualify for designation as an RRC. In promulgating these regulations, HCFA published several statements in the Federal Register indicating that providers seeking designation for 1986 were required to qualify on the basis of 1985 operational data [50 Fed. Reg. 35,673, 35,675, 35,677 (Sept. 3, 1985)].⁶ The Provider contends that the narrative accompanying the publication of the regulations clearly indicated that 1985 was the relevant base year for 1986 RRC designations. While HCFA published a correction to the earlier regulations in an attempt to clarify the relevant operational period to be used in applying for 1986 RRC designation [50 Fed. Reg. 43,570 (Oct. 28, 1985)],⁷ the Provider argues that the corrected version compounded the error by retaining the prior year discharge requirement. Since the Provider did not qualify under one of the criteria based on its 1985 data (i.e. - it did not have the requisite 6,000 discharges in 1985), the Provider did not apply for RRC designation during the 1986 application period (last quarter of 1985).⁸

The Provider contends that HCFA did not correct the misstated eligibility criteria until late 1986, nine months after the 1986 application period had elapsed. On September 3, 1986, HCFA issued a correction to the PPS regulations stating that the controlling discharge data for eligibility were discharges from the year two years prior to the RRC designation year [51 Fed. Reg. 31,472 (Sept. 3, 1986)].⁹ Contrary to the Intermediary's contention that this was intended to be a change in policy for 1987, the Provider notes that HCFA expressly stated that discharge data for fiscal year 1984 controlled RRC eligibility for fiscal year 1986. Despite the correction made in late 1986, HCFA continued to take the position that applications for 1986 were required to be submitted during the last quarter of 1985. The Provider recognizes the value and importance of deadlines in application processes. However, in the instant case, the agency charged with issuing eligibility criteria systematically misled providers as to the controlling base year data. Based on the published eligibility criteria that existed in late 1985, the Provider would not have been eligible for RRC status in 1986. Accordingly, there was no basis for the Provider to file an application for 1986 during the last quarter of 1985 as part of a challenge to the unmet discharge criterion.

⁶ Provider Exhibit 3.

⁷ Provider Exhibit 4.

⁸ On April 28, 1986, the Provider did file a pro forma request for RRC designation for 1986 even though it didn't qualify under published eligibility criteria. On advise of legal counsel, the Provider attempted to qualify by counting newborn as well as adult discharges. While the Provider has since abandoned this theory, its request was denied because it was untimely.

⁹ Provider Exhibit 6.

The Provider argues that HCFA's actions were arbitrary and capricious, and frustrated the Congressional intent of the RRC payment adjustment. In implementing the provisions of 42 U.S.C. § 1395ww(d)(5)(C)(i), Congress ordered the Secretary to provide a special payment adjustment for RRCs. The Secretary was directed to establish and timely publish eligibility criteria to guide providers as to whether they should apply within a specified time period after the standards were published.¹⁰ The Provider argues that the statutory language directly links this requirement of timely publication of the eligibility criteria to the application procedure indicating that providers should apply during the quarter before the first quarter of the provider's cost reporting period. The Provider believes that the most generous interpretation for HCFA's late publication of the controlling criteria is that it was negligent in misdescribing the base period for discharge data. In effect, HCFA advised that it was pointless to apply for RRC designation for 1986 unless the provider had 6,000 discharges in 1985. After the application deadline passed, HCFA announced that the published criteria had been misstated. When the Provider later qualified for 1986 under the actual eligibility criteria established, HCFA then invoked a "catch 22" and advised the Provider that it was too late. The Provider insists that without the required prior publication of the actual eligibility standards, the associated application deadline established by Congress would not be applicable.

The Provider argues that it is well established that where an agency's regulations are not "ascertainably certain," a regulated party is not on notice of the agency's ultimate interpretation of the regulations and cannot be punished for failing to comply with that interpretation. In support of this premise, the Provider cites several court decisions including General Electric Company v. United States Environmental Protection Agency, 53 F.3d 1324 (D.C. Cir. 1995).¹¹ Upon being fined for actions found to be inconsistent with regulations, General Electric contended that the regulations were unclear and that it acted in accord with its understating of them. The Court held that even though the agency's interpretation of its regulations was permissible, the regulations were unclear and, thus, did not provide General Electric with fair notice of the agency's interpretation. The Provider asserts that, in the present case, the regulations were ambiguous and HCFA's explanation clearly and plainly misstated that the relevant base period was the year prior to the RRC designation year. Since HCFA could not identify the base period with "ascertainable certainty," the Provider believes it is manifestly unfair that it be punished for being unable to do so.

The Provider notes that the HCFA Administrator has applied the fair notice standard to Medicare application procedures where providers received ambiguous or misleading information. In Valley Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D7, November 21, 1994, Medicare and Medicaid Guide

¹⁰ Provider Exhibit 2.

¹¹ Provider Exhibit 9.

(CCH) ¶ 42,909, rem'd by HCFA Admin., January 17, 1995,¹² the intermediary refused to accept additional information pertaining to an exception request because it was not completed within three years of the notice of program reimbursement for the year at issue. While the Administrator found HCFA's application of the three-year rule valid, the case was remanded to the Board stating the following:

[t]hat the Provider in this case did not receive timely notice of the filing deadline for completed exception requests . . . compels the Administrator to remand this case for further consideration. That is, the record indicates that the Provider was not notified, or otherwise made aware of, the three-year filing deadline for completed applications until May 1986. Further, the Intermediary's notice to the Provider concerning the deadline contained ambiguities regarding the exact date of the deadline. Accordingly . . . the Administrator . . . remands this matter so that the Provider may complete its application and HCFA may review the request under the applicable guidelines established by regulation and program memoranda.

Id. (emphasis added).

The Provider believes an analogous set of facts exists in the present case where (1) the only timely notice given was worse than ambiguous, it was incorrect, and (2) the only definitive, clear notification of the controlling standards came nine months too late.

In response to the Intermediary's argument that HCFA clearly identified the application period for obtaining RRC designation, the Provider points out that it is not disputing whether the application period was clearly identified. What is in dispute is the clarity of the eligibility criteria, specifically the base period to be used in applying for RRC designation in 1986. Because HCFA originally stated that 1985 data were to be used to qualify for 1986, the Provider believed there was no basis to apply. While the Intermediary states that the RRC regulations were revised in 1986 to permit the use of 1984 data to determine RRC eligibility for 1986, the Provider argues that this translation mischaracterizes the nature and effect of the 1986 revisions to the regulations. In revising the regulations, HCFA was not permitting the use of 1984 data for an initial application of RRC status in 1986. Rather, HCFA stated that all currently approved RRCs seeking triennial recertification shall use information from the year two years prior to the redesignation, because that is the period for applying the discharge standard for hospitals initially seeking such status. Accordingly, HCFA was mandating that 1984 operational data were to be used for initial RRC designations effective in 1986.

Contrary to the Intermediary's position, the Provider asserts that it is not seeking to apply a more liberal criteria emanating from the regulatory revision in 1986. The Provider has always maintained that it sought to have its fiscal year 1986 application evaluated under the

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Provider Exhibit 12.

substantive criteria announced in the September 3, 1985 Federal Register, and not under the substantive criteria for any later year. The examples cited in that Federal Register [50 Fed. Reg. 35,677 (Sept. 3, 1985)] expressly discuss RRC designations for 1986 on the basis of fiscal year 1985 data. Had the examples been correct, they would have stated that 1986 applications must be based on 1984 operational data. The Provider explains that it did not file an application in 1985 because it knew it did not qualify for RRC status in 1986 on the basis of its 1985 data. Had the examples and other statements in the September 3, 1985 Federal Register been accurate, the Provider avers that it would have timely applied because it clearly was qualified on the basis of its 1984 operational data.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA's initial regulatory criteria for meeting RRC status were set forth in 42 C.F.R. § 405.476(g) (now 42 C.F.R. § 412.96) published in the September 1, 1983 Federal Register (42 Fed. Reg. 39,827 - 39,828).¹³ Responding to industry comments as to the stringency of the initial criteria, HCFA modified the final regulatory rule in the January 3, 1984 Federal Register (49 Fed. Reg. 274-276),¹⁴ which included the following statement:

Since there is no generally accepted definition of referral centers, it is not possible at this time to determine which payment adjustments are appropriate. This is because we will not know how referral center costs are atypical when compared to other hospitals until we have an opportunity to examine and analyze in detail the data pertaining to those hospitals (other than large rural hospitals) which apply for referral center status. Only when we have completed an analysis will we be able to determine in what ways referral centers are atypical when compared to other hospitals with respect to their costs, and to then develop an appropriate adjustment.

49 Fed. Reg. 276 (Jan. 3, 1984).

In the August 31, 1984 Federal Register (49 Fed. Reg. 34,761 - 34,763),¹⁵ revised regulatory criteria were promulgated to expand the definition of a referral center to encompass more rural hospitals. Prior to the publication of the final rule, Public Law ("PL") 98-369 was enacted by Congress which included a provision that rural hospitals could appeal to the

¹³ Intermediary Exhibit I-1.

¹⁴ Intermediary Exhibit I-3.

¹⁵ Intermediary Exhibit I-4.

Secretary to be classified as RRCs based on criteria established by the Secretary.¹⁶ Section 2311(a) of PL 98-369 stated the following in pertinent part:

An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

Id. (emphasis added).

The Intermediary points out that HCFA referred to Section 2311(a) of PL 98-369 in the Federal Register published August 31, 1984 by stating the following:

In the NPRM, we stated that the criteria published in § 405.476(g)(1)(i) and (ii) and the criteria proposed in § 405.476(g)(1)(iii) would be effective for discharges occurring on or after October 1, 1984. However, after the NPRM was published, Pub. L. 98-369 was enacted. Section 2311(a) of Pub. L. 98-369 states that a hospital must submit its request for rural referral center status during the quarter preceding the start of its fiscal year (except that hospitals with a fiscal year starting on October 1, 1984 have until January 1, 1985 to submit their requests). Based on the law, we are altering our proposed effective date to conform with the statutory requirement. If we determine that a hospital meets the criteria for rural referral center status, payments will be effective with the start of the provider's cost reporting period.

Id. at 34,743.¹⁷

The Intermediary argues that the Provider failed to abide by a statutorily prescribed deadline for filing for RRC status. Consequently, all of the Provider's ancillary arguments are unavailing. Contrary to the Provider's statement that it had been misled into not applying in 1985 because of HCFA's failure to publish the controlling eligibility criteria until late in 1986, the Intermediary points out that the Provider did seek RRC status in April of 1986. Accordingly, the Provider sought RRC status prior to HCFA's promulgation of the final PPS rule revising the RRC classification criteria in the Federal Register published September 3, 1986. While the Provider asserts that the regulations were ambiguous and even suggests

¹⁶ Intermediary Exhibit I-5.

¹⁷ Intermediary Exhibit I-4.

sinister motives on the part of HCFA, the Intermediary insists that the only issue before the Board in this appeal is the Provider's failure to meet a filing deadline.

The Intermediary contends that the Provider was on notice as early as July 18, 1984, the date of enactment of PL 98-369, that appeals for RRC status must be submitted during the quarter before the first quarter of the hospital's applicable cost reporting period. When the RRC criteria were liberalized for cost reporting periods beginning on or after October 1, 1985 in the September 3, 1986 Federal Register, the Provider discovered that it might qualify for RRC status for its December 31, 1986 cost reporting period. The Intermediary argues that the issue in this case is not whether the Provider met the criteria for RRC status for its December 31, 1986 reporting period, but whether the Intermediary should apply more liberal RRC regulations retroactively when the statutorily prescribed time requirements for filing an appeal were not met in the first place.

In further support of its position, the Intermediary cites the Board's decision in Appalachian Regional Healthcare, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Kentucky, PRRB Dec. No. 96-D39, June 26, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,494 ("Appalachian").¹⁸ In Appalachian, the Board upheld the intermediary's denial of RRC status stating as follows:

When adjudicating an agency's interpretation of a statute it administers, principles of statutory construction require the application of the two step test established by the United States Supreme Court in Chevron v. Natural Resources Defense Council, 467 U.S. 837 (1984) ("Chevron"). See DAVIS ADMINISTRATIVE LAW § 3.2, 109-110 (3d ed. 1994) ("DAVIS"). The first part of that test requires a determination of whether Congress did or did not expressly speak to the question at issue. If the answer is no, then an examination of the permissibility of the agency's construction is the next step.

Id.

The Intermediary asserts that Congress clearly addressed the question at issue in the instant case by specifying a deadline for filing RRC appeals in Section 2311(a) of PL 98-369. As in the current appeal, the provider in Appalachian was also granted RRC status for the fiscal year subsequent to the year at issue under revised eligibility criteria. The Board addressed this matter by stating the following:

The Board also finds that the Provider's subsequent receipt of RRC status . . . is not relevant to this appeal. Consistent with the Board's findings above, RRC status is evaluated on a very time specific basis. Evidence of subsequent

¹⁸ Intermediary Exhibit I-15.

favorable status does not have any bearing on an applicant’s eligibility for a previous determination period.

Id. (emphasis added).

The Intermediary believes a similar finding is warranted in this appeal because the Provider did not comply with statutory requirements. Further, HCFA’s subsequent revision of RRC eligibility criteria should have no bearing on the Provider’s appeal for the fiscal year ended December 31, 1986. In the September 3, 1985 final rule implementing the fiscal year 1986 PPS rates,¹⁹ HCFA clearly stated that the RRC eligibility criteria and the periods to which they apply are time specific:

The August 31, 1984 final rule specified that the alternative criteria published at § 405.476(g)(iii) (redesignated as § 412.96(c)) were effective for cost reporting periods beginning on or after October 1, 1984. The revised criteria set forth in this final rule are effective with cost reporting periods beginning on after October 1, 1985. Thus, we believe the distinction between the earlier and revised sets of criteria and the periods to which they are applicable is clear. It has always been true for the most part that when dealing with the criteria applicable to a particular period of time, one must return to the regulations in effect at that time.

50 Fed. Reg. 35,673 (Sept. 3, 1985).

The Intermediary maintains that it is the Provider’s failure to comply with a statutory directive, not a HCFA regulation, which should be dispositive of the outcome in this appeal. Accordingly, the Intermediary concludes that its August 1, 1986 denial of the Provider’s April 28, 1986 RRC designation request for the fiscal year ended December 31, 1986 should be affirmed by the Board.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:
 - § 1395x(v)(1)(A) - Reasonable Costs
 - § 1395ww(d)(5)(C) - Rural Referral Center Qualification
2. Regulations - 42 C.F.R.:
 - §§ 405.1835-.1841 - Board Jurisdiction

¹⁹ Intermediary Exhibit I-16.

§ 412.96 - Rural Referral Center Qualification
[Formerly 405.476(g)]

3. Case Law:

Chevron v. Natural Resources Defense Council, 467 U.S. 837 (1984).

General Electric Company v. United States Environmental Protection Agency, 53 F.3d 1324 (D.C. Cir. 1995).

Valley Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D7, November 21, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,909, rem'd by HCFA Admin., January 17, 1995.

Appalachian Regional Healthcare, Inc., v. Blue Cross and Blue Shield Association/Blue Cross of Kentucky, PRRB Dec. No. 96-D39, June 26, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,494.

4. Other:

(a) PL 98-369 - Deficit Reduction Act of 1984
Section 2311 - Classification of Certain Rural Hospitals

(b) Federal Register:

42 Fed. Reg. 39,827 - 39,828 (Sept. 1, 1983).

49 Fed. Reg. 274 - 276 (Jan. 3, 1984).

49 Fed. Reg. 34,742 - 34,743, 34,761 - 34,763 (Aug. 31, 1984).

50 Fed. Reg. 35,673, 35,675, 35,677 (Sept. 3, 1985).

50 Fed. Reg. 43,570 (Oct. 28, 1985).

51 Fed. Reg. 31,472, 51,545 (Sept. 3, 1986).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSIONS:

The Board, after consideration of the controlling law and regulations, the facts of the case, parties' contentions and evidence presented in the record, finds and concludes that the Intermediary properly denied the Provider's request for rural referral center status for the fiscal year ended December 31, 1986.

The Board finds that the statutory provision of Section 2311(a) of PL 98-369 explicitly states that an appeal for RRC classification "must be submitted during the quarter before the first quarter of the hospital's cost reporting period." Since the Provider did not file its request for

RRC designation for the fiscal year ended December 31, 1986 until April 28, 1986, the Provider failed to comply with the filing deadline established by the statutory directive. The Board is bound by this controlling statutory provision.

DECISION AND ORDER:

The Intermediary properly denied the Provider's request for rural referral center status for the fiscal year ended December 31, 1986. The Intermediary's denial due to untimely filing is upheld pursuant to Section 2311(a) of PL 98-369.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: February 13, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman